STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 15, 16,17, 20, 2011 Facility number: 000517 Provider number: 155714 AIM number: 100266770 Survey team: Liz Harper, RN- TC Carole McDaniel, RN Terri Walters, RN Martha Saull, RN, June 15, 16, 17, 2011 Census bed type: SNF/NF: 31 Total: 31 Census payor type: Medicare: 4 Medicaid: 21 Other: 6 Total: 31 Sample: 10 Supplemental sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegatin of compliance effective July 9, 2011 to the annual survey conducted on July 15th, 16th, 17th, and 20th, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on June 23, 2011, by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure staff reported immediately witnessed verbal abuse and mistreatment for 1 of 1 resident allegations of abuse reviewed.	F0225	F225 F – 225 The corrective action taken for those residents found to have been affected by the deficient practice is the staff member who was found to have been neglectful and verbally	07/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CNA #1, CNA #2, Resident #16 Findings include: On 6/16/11 at 1:45 P.M., the DON was interviewed. He indicated when staff would inform him of an actual or alleged abuse incident, he would have them complete a written deposition to use as a follow up tool. He indicated he would also interview the resident and start an investigation. The DON indicated if the "incident was not significant" and occurred in the middle of the night, he would wait until the morning to notify the Administrator. The DON gave an example of an incident he would wait until the next morning to notify the Administrator of as having been a resident to resident physical altercation with no injury and had not required the resident to go to the hospital for evaluation. The DON indicated if there was an incident of staff to resident verbal abuse during night hours, he would send the involved staff member home and would call the Administrator the next morning. On 6/17/11 at 11 A.M., the Administrator provided a copy of an abuse investigation. This investigation was dated as the incident occurring 3/4/11 between 2 A.M. and 3 A.M. Explanation of the incident		abusive following a thorough investigation was terminated. The staff member who failed to report the incident concerning resident # 16 and CNA # 2 was inserviced on policy and procedure for reporting abuse and/or neglect and received a 2 day suspension at the discretion of the DON. The corrective action taken to identify other residents having the potential to be affected is that all residents have the potential to be affected. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that the Policy & Procedure for reporting abuse has been revised to include all suspected abuse be reported immediately to the charge nurse who will then report to the DON and Administrator immediately. The revision contains disciplinary action for failure to report an incidence of abuse immediately to Charge Nurse. The measures or systemic changes that will be made to ensure that the deficient practice does not recur is that an all staff inservice was conducted to address what constitutes abuse and that there are no insignificant incidents of abuse/neglect Also specifically the reporting of suspected abuse. Further includes disciplinary action of a mandatory two (2) day suspension for failure to report incident and can include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, but was not limited to, the following: "From conversation with resident, res (resident) c/o (complained of) telling CNA (certified nursing assistant) that she was cold and wet. CNA raised and lowered her arms in disgust (sic) and walked out of the res room and did not return. Another CNA did come to give res care..." At this time, the Administrator also provided a copy of her investigation of the above incident. This investigation included, but was not limited to, the following: "At approximately 10 A.M., on 3/4/11, I was told by Social Service that (Resident #16) had told her that she had been left wet and cold during the night..." At this time a copy of CNA #1's written statement was reviewed. This undated and timed statement included, but was not limited to, the following: "I (CNA #1 name) was a witness on 3/4/11 in Res (#16) room to the aide (CNA #2) responding to (Resident #16) crying about wetting bed and not able to get herself up to transfer to the commode. CNA #2 stated 'Everyone babies you, that's why your (sic) like this. You know better, cause I'm not going to'." CNA #1 documented "In the matter of (Resident #16) (CNA #2 name) and I were doing bed check up the long hall... (Resident #16) light went on and (CNA #2) said, "she'll have to wait." CNA #2 documented "When we approached		termination. The corrective actions taken to monitor and ensure performance is that a Quality Improvement Tool has been implemented to monitor the reporting of suspected abuse. This tool will be completed by Charge Nurse daily on each shift for three weeks and then with each incidence of suspected abuse. Tools will be reviewed by DON.daily Monday through Friday for three weeks and then with each incident. This information will Also bereviewed each month in QA meeting to see if further action is warranted. Compliance Date 7-9-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Resident #16 room) I went to (Resident #17, Resident #16's roommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M. - 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed from CNA #2 to Resident #16. 3.1-28(c)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure staff followed the policy and procedure for reporting observed abuse to the charge nurse and ultimately to the Administrator for 1 of 1 resident allegations of abuse reviewed. Resident #16, CNA #1 Findings include: On 6/16/11 at 1:45 P.M., the DON was interviewed. He indicated when staff would inform him of an actual or alleged abuse incident, he would have them complete a written deposition to use as a	F0226	F226 It is and shall continue to be the facilities practice that all incidents of abuse, neglect, mistreatment of residents or misappropriation of their property reported immediately to the DON and the Administrator The corrective action taken for those residents found to have been affected by the deficient practice is that the facility Policy and Procedure on prohibition of mistreatment, neglect and abuse of residents and misappropriation of resident property was revised to include specific reporting of abuse immediately to charge nurse who will immediately report the incident to the DON and	07/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	follow up tool. He indicated he would also interview the resident and start an investigation. The DON indicated if the "incident was not significant" and occurred in the middle of the night, he would wait until the morning to notify the administrator. The DON gave an example of an incident he would wait until the next morning to notify the Administrator of as having been a resident to resident physical altercation with no injury and had not required the resident to go to the hospital for evaluation. The DON indicated if there was an incident of staff to resident verbal abuse during night hours, he would send the involved staff member home and would call the Administrator the next morning. On 6/17/11 at 11 A.M., the Administrator provided a copy of an abuse investigation. This investigation was dated as the incident occurring 3/4/11 between 2 A.M. and 3 A.M. Explanation of incident included, but was not limited to, the following: "From conversation with resident, res (resident) c/o (complained of) telling CNA (certified nursing assistant) that she was cold and wet. CNA raised and lowered her arms in disgust (sic) and walked out of the res room and did not return. Another CNA did come to give res care..." At this time, the Administrator also provided a copy of her		Administrator. The resident identified as resident #16 has suffered no negative psychological outcome from this event. The corrective action taken to identify residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that the Policy and Procedure for reporting abuse has been revised to include all suspected abuse be reported immediately to the charge nurse who will then report to the Don and Administrator immediately. The revision contains disciplinary action for failure to report an incidence of abuse immediately to the charge nurse. The measures or systemic changes that will be made to ensure that the deficient practice does not recur is that an all staff in-service was conducted with the revised Policy and Procedure on prohibition of mistreatment neglect and abuse of residents and misappropriation of resident property. In-service addressed what constitutes abuse and specifically the reporting of suspected abuse. The in-service also stressed that there is no such thing that is considered an insignificant incidents of abuse/neglect. The in-service also emphasized that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	investigation of the above incident. This investigation included, but was not limited to, the following: "At approximately 10 A.M., on 3/4/11, I was told by Social Service that (Resident #16) had told her that she had been left wet and cold during the night..." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M. - 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. On 6/17/11 at 12:45 P.M., the DON was interviewed. He indicated the facility currently did not have a policy and procedure to address staff being disciplined in response to an abuse allegation and/or actual abuse but indicated the facility will develop one and implement it. On 6/15/11 at 2 P.M., a current copy of the facility policy and procedure was received from the Administrator. The policy was undated. The procedure included, but was not limited to, the following: "1. Resident,		the revised policy includes disciplinary action for confirmed abuse by an employee and for failure to report an incident of abuse/neglect. The staff was also advised that a mandatory two (2) day suspension will be enforced for failure to report incident immediately and can result in termination. Residents will also be protected from the potential threat of abuse by relieving suspected staff member of their duties for not less than a period of three days while a thorough investigation is conducted. All confirmed incidents of neglect/abuse involving a staff member will result in termination. The corrective actions will be monitored to ensure the deficient practice will not recur is that a Quality Improvement Tool has been implemented to ensure revised Policy and Procedure is available to all staff, All Policy and procedures will be dated to ensure the most current one is being used. Improvement Performance Tool will be completed daily by DON for three weeks, monthly for three months and quarterly times3. This tool will be reviewed in monthly QA meeting to see if further action is warranted. Compliance Date 7-9-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	family...concerns regarding abuse, neglect...are to be recorded on a complaint form and forwarded to the Director of Nursing (DON) and/or the Administrator...The charge nurse will also notify the Director of Nursing, Social Services and/or the Administrator...If the alleged concern involves the charge nurse, the allegation will be immediately reported to the DON, Social Services and/or the Administrator. 3.1-28(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure 1 of 1 Qualified Medication Aide (QMA) was administering pain medication with professional nurse oversight to 1 of 6 residents from a supplemental sample of 6 who were observed receiving medication from a QMA during medication pass. Resident #32	F0282	F282 It is and shall continue to be the facility's practice that services are performed by qualified persons/per their plan of care. The corrective action taken for the resident affected by this deficient practice is that QMA # 1 was given a verbal warning and was counseled on the regulation that a QMA consult a licensed nurse before passing a PRN medication. Also document in the resident record symptoms	07/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: On 6/15/11 at 11:10 A.M., Resident #32 approached the medication cart from which QMA#1 was passing medication. Resident #32 stated "I need some Tylenol." QMA#1 responded by saying "OK, I'll bring some to your room." The QMA failed to consult a licensed nurse and prepared 2 tablets of Acetaminophen (generic Tylenol) 325 mg., which she gave to the resident. Before administering the medication to the resident, she asked the resident where her pain was located. Resident #32 indicated she had a headache. The QMA administered the drug and instructed the resident to "Let me know if that doesn't help." The QMA returned to her cart, directly outside the room of Resident # 32. At that point LPN #1 came to the cart and asked the QMA for keys to open the other medication cart. The QMA provided keys but did not inform the nurse of Resident #32's pain or the administration of the Acetaminophen. The QMA then documented the drug, date, time, and reason she had given the medication to Resident #32. The clinical record of Resident #32 was reviewed on 6/15/11 at 11:50 A.M. The resident had been admitted 5/13/11 and had a physician order for 2		indicating the need for medication and time the symptoms occurred, document in the record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication including the time of contact, obtain permission to administer the medication each time the symptoms occur in the resident and ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse is on call by the end of the nurse's next tour of duty. It should also be noted that the resident identified as resident #32 had no negative outcome from receiving the prn dose of Tylenol. The measures or systemic changes that have been put into place to ensure the deficient practice does not recur is that a mandatory in-service was conducted for nursing staff and the QMA. Specifically addressed was the regulation that a QMA consult a licensed nurse and complete necessary documentation before passing a PRN medication and that the nurse authorizing the administration of the prn medication co-signs the drug administration record. The corrective action taken to monitor to ensure the deficient practice does not recur is the that a Quality Improvement tool was developed and implemented to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Acetaminophen 325 mg tablets by mouth every 4 hours prn (as needed) for pain or elevated temperature. At 6/15/11 at 12:50 P.M., LPN #1 was interviewed regarding QMAs administering prn medication. She indicated she believed it was fine for QMA's to give prn medications without consulting the nurse unless the prn's were narcotics and Acetaminophen was not a narcotic. The Director of Nursing provided the undated Job Description "MED PASS STAFF - QMA OR LPN" on 6/17/11 at 12:05 P.M. It directed "QMA to report to charge nurse any PRN medications given." The State rule 412 IAC 2-1-9 Scope of Practice in reference to QMAs was reviewed on 6/17/11 at 1:00 P.M. It contained Qualified Medication Aide Rule #1 Sec 9(a)(11) on page 5 which read as follows: "Administer previously ordered pro re nata (prn) medication only if authorization is obtained from the facility nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for		monitor the passing of PRN medications by a QMA. The tool includes a review of all required documentation components that the QMA and nurse are required to complete upon the administration of a prn medication. This tool will be completed by the Charge Nurse each day a QMA is utilized in the facility. This tool will be monitored by the DON weekly times 3 weeks, monthly times 3 months and quarterly times 3. The outcome will be reviewed in Monthly Quality Assurance meeting to see if further action is warranted. Completion Date 7-9-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication and time the symptoms occurred. (B) Document in the resident record that the facility's Licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse is on call, by the end of the nurse's next tour of duty." 3.1-35(g)(2)			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure interventions were formulated, revised or implemented to address multiple falls for 2 of 5 residents reviewed for falls in the sample of 10. This practice resulted in Resident #1 falling and sustaining a hip fracture. In addition, the facility failed to ensure measures were in place to prevent environmental hazards posed by the	F0323	F323 F323 It is and shall continue to be the facility's practice that the facility ensure that the resident environment remain as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. The corrective action taken for the resident found to have been affected by the deficient practice is that resident #1 careplan has	07/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility vacuuming system Resident #1 and 18 Findings include: 1. The clinical record of Resident #1 was reviewed on 6/15/11 at 11:15 A.M. Diagnoses included but were not limited to the following: History of Right Hip Fracture, Dementia, History of Stroke, Chronic anemia and dysarrhythmia. The admission MDS (Minimum Data Set assessment), dated 10/19/10, indicated the following for the resident: severe cognitive impairment; transfers and ambulation required extensive assistance; limited assistance was required for toileting. The resident was admitted to the facility on 10/6/10. A care plan, dated 10/7/10, identified the following problem: "At risk for falls due to hx of falls et (and unsteady gait." Interventions included, but were not limited to, the following: "Transfer et (and) walk with one assist; pull alarm at all times; call light within reach; up in wc (wheelchair) prn (as needed) when unsteady on feet; pressure pad alarm at all times..." Documentation was lacking as to the dates of implementation of the interventions.		been audited to ensure all interventions are dated. New interventions have been implemented to help prevent further falls. All fall assessments will be completed according to Policy and Procedure. It should also be noted that the resident identified as resident #1 has not had any falls since the survey. The corrective action taken to identify other residents having the potential to be affected is that all residents identified as being a fall risk have the potential to be affected. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that a Falls Committee has been formed to review all residents who are at risk for falls. An audit was performed to ensure that all residents with a risk for falls has the proper interventions careplanned and the proper documentation. The committee meets each day Monday thru Friday to review any new falls, interventions, documentation, medications, diagnoses, and careplan, Fall Investigation Report and nurse's notes. It shuld also be noted that the fall investigation includes potential cause factors. This information is then utilized to determine appropriate interventions to be utilized in an attempt to prevent future falls. The measures or systemic changes put into place to ensure that the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nurses notes indicated the following for the resident: 10/6/10 at 4:20 P.M.: "...Resident is alert but confused, pressure pad alarm placed on resident's bed at this time..." 10/6/10 at 7 P.M.: "...Taking other resident's alarm off had to sit her where she can not reach other resident's alarms..." 10/7/10 at 5:50 A.M.: "...This nurse has answered her alarm 9 x in under 30 minutes. Will cont (continue) to monitor et (and) provide interventions..." 10/9/10 at 7 P.M.: "...very confused. Attempting to stand et walk 12 x's (times) in 30 minutes..." 10/9/10 at 8:30 P.M.: "...yelling at staff et other res. Res cont (continue) to try to get up out of chair. Staff having to provided 1:1 with res." 10/10/10 at 1:30 A.M.: "...Res requires a lot of one on ones d/t (due to) increased confusion...Pressure pad in place et working properly but res still stands up per self et ambulates." 10/10/10 at 10 A.M.: "...has been standing up several times this A.M..."		practice does not recur is that an all nursing staff inservice was conducted on the proper procedure for completing the fall risk assessment, nurse's notes and the plan of care. The corrective action taken to ensure the deficient practice does not recur is the implementation of a Quality Performance Tool. This tool is a follow up check list to be completed with each fall. This tool will be monitored by the DON as each fall occurs. This tool will be reviewed daily along with the Fall Investigation Report and the nurse's notes, careplan and Fall Risk Assessment during the Fall Committee meeting. 2. The corrective action taken for the resident (#18) found to have been affected by the deficient practice is that the Safety Committee has completed a house wide inspection of the facility to identify any safety hazards.Housekeeping has also implemented the practice of wet to dry mopping of the dining room floors. It should also be noted that the resident identified as resident #18 has not had any falls since the survey. The corrective action taken to identify other residents having the potential to be affected is that all residents have to potential to be affected. The corrective action taken is that a house wide inspection of the facility has been completed to identify any safety hazards. Any potential safety hazards that were identified have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/10/10 at 7:10 P.M.: "...up in chair at nurses station, cont to try to get out of chair, 1:1 attention given..." 10/11/10 at 2:55 A.M., (Fall #1): "Resident was found on the floor at the north side of the nurses station. The alarm (pressure pad) was sounding. The fall was not witness (sic)...a pull alarm was added..." 11/3/10 at 9:10 P.M., (Fall #2): "Res got up et as CNAs (Certified Nursing Assistants) were going to assist res to ambulate et before CNAs could reach res she fell backwards et hit head on wall on way to floor..." 11/4/10 at 1 A.M.: "Nurse of (hospital name) ER (emergency room) called (sic) reported res has hematoma to back of head. CT (computerized tomography) scan neg (negative)..." 11/4/10 9 A.M.: "...cont with knott [sic] et bruise on back of head..." 11/5/10 at 9:20 A.M., (Fall #3): This nurse was alerted by res alarms sounding. Res was standing in west hall way. This nurse attempted to reach res. Unable to stop res from falling on bottom. Fall witnessed by this nurse..."		been corrected. The measures or systemic changes put into place to ensure that the deficient practice does not recur is an all staff inservice has been conducted specific to safety and identifying and reporting of safety hazards due to construction or any other hazard. Maintenance has been inserviced on the Policy and Procedure for identifying and removing safety hazards. Housekeeping was inserviced on the practice of wet to dry mopping of the dining room floors. The corrective action taken to ensure the deficient practice does not recur is the implementation of a Quality Performance Tool. This tool will be completed by Maintenance daily times 3 weeks then monthly times 3 months and then quarterly for three quarters.. This tool will also be used daily at any time there is construction in the facility. This tool will be monitored by Administrator and reviewed in monthly QA meeting to see if further action is warranted. A Quality Performance Tool has also been implemented for Housekeeping Supervisor. This tool will be completed 1 time daily for three weeks, weekly times four weeks and quarterly for three quarters. The outcome of these tools will be reviewed in QA meeting to see if further action is warranted. 3. The corrective action taken for those residents found to have been affected by the deficient practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11/5/10 at 2 P.M., "Pressure floor mat alarm next to bed to alert staff to movement...PPA (pressure pad alarm) while up in w/c (wheelchair) or chair. D/C (discontinue) pull tab alarm d/t res. removes per self..." 11/5/10 at 6:30 P.M., (Fall #4): This CNA was assisting another res in the east wing bathroom et [and] heard alarm sounding. As I walked out of bathroom observed res lying on floor at nsg station et alarms sounding. Res was lying in fetal position..." 11/9/10 at 7:05 P.M., (Fall #5): "Resident was lying in bed...Aide was going down the hall with another resident when he heard pressure pad ringing and mat alarm ringing. Aide tried to get to resident before aide could reach her. Resident fell backwards and hit head on the wall..." 11/11/10 at 4 P.M., "...up and down the hall in w/c, standing up setting off alarm..." 11/11/10 at 12:10 A.M., (Fall #6): "Heard res alarm sounding et went to check res. Upon entering rm (room) found her on floor beside bed. Unable to obtain infor (information) from res r/t (related to) fall..."		identified as vacuuming of floors is that no specific residents were identified. The corrective action taken for those residents having the potential to be affected by the deficient practice is that all residents have the potential to be affected. The corrective action taken for those residents with the potential to be affected is that a Policy and Procedure for the vacuuming of floors has been developed and implemented. The measures or systemic changes put into place to ensure that the deficient practice does not recur is that all Housekeeping staff was inserviced on the policy and procedure for vacuuming. The corrective action taken to ensure the deficient practice does not recur is the implementation of a Quality Performance Tool. This tool will be used by Housekeeping Supervisor 1x daily for three weeks, weekly for three weeks, then monthly three months and quarterly for three quarters. This tool will be reviewed in the monthly Quality Assurance meeting to see if further action is warranted. Compliance date 7-9-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

11/12/10 at 5:10 P.M., (Fall #7): "Resident was sitting at nurses station, had been up and down all shift. Pressure pad alarm ringing. Saw resident fall, landed on bottom. Did not hit head..."

11/14/10 at 5:20 A.M., (Fall #8): "This nurse was approaching nsg. station et hskg (housekeeping) alerted this nurse to res sitting on floor with alarm sounding..."

11/14/10 at 6:50 A.M., (Fall #9): "This nurse was on east wing hall when personal alarm sounded, alerting this nurse. Noted at NS (nurses station) res laying on floor on r (right) side with R side of head on edge of w/c next to res's (residents)...slight inward rotation of the R leg..."

11/14/10 at 10:30 A.M., "Res admitted to (hospital name) ..."

A policy and procedure for "Incident/Accident Report" was dated 3/8/07 and was received from the DON on 6/17/11 at 7:50 A.M. The purpose of this policy, included but was not limited to, the following: "...Document the events of an incident/accident...To investigate and evaluate such occurrences with the intent of minimizing the likelihood of recurrence." Policy included but not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to the following: "...Complete all information on the Incident/Accident report form. Do not leave blanks...Follow up documentation is to be done by the nurse on each shift...Fill out post fall assessment form for 3 consecutive days following the incident/occurrence and when form is completed turn into DON." On 6/16/11 at 1:20 P.M., the DON was interviewed. He indicated the resident had a history of falls at home prior to her admission to the facility. He also indicated the following information: Regarding the 11/3/10 fall (Fall #2), he didn't know what intervention was put into place after this fall as a preventative measure. Also with the 11/3/10 fall, the DON indicated the resident was found in the hall, but didn't know which alarm was sounding. Regarding the 11/5/10 fall (Fall #3), the DON indicated he didn't know what, if any, preventative intervention was put into place and if one was put into place, it wasn't documented. For the fall on 11/5/10 (Fall #4) and 11/9/10 (Fall #5) and 11/11/10 (Fall #6) and 11/12/10 (Fall #7) and 11/14/10 at 5:20 A.M. (Fall #8), the DON indicated no new preventative intervention was documented. The DON indicated that the facility "tried to keep her occupied." He indicated the fall on 11/14/10 at 6:50 A.M., resulted in a fracture to the resident's right hip. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DON indicated at this time that the resident's room was on the West hall. 2. The clinical record of Resident # 18 was reviewed on 6/15/11 at 11:00 A.M. Diagnosis included but were not limited to Dementia and History of falls. The Minimum Data Set Assessment MDS) of 3/16/11 indicated the resident had fallen since the last assessment. The nurses' notes reflected a fall since the 3/16/11 assessment. Accounts of each fall were provided by the Director of Nursing (DON) on 6/15/11 at 1:00 P.M. The accounts were Fall Investigation Reports. The Fall Investigation Reports indicated falls were related to facility hazards. One on 1/26/11 at 9:35 P.M., indicated the resident had fallen on a roll of carpet in West hallway due to "new carpet being put in the building." The prevention strategy initiated to prevent additional falls was "Move carpet over to wall and observe residents closely in hallway with rolls of carpet." Another fall on 3/21/11 at 11:00 A.M., occurred when according to the report, the resident slipped on the dining room floor, which was wet from mopping. The planned intervention was for housekeeping to dry mop flooring in the dining room after wet mopping it. During			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview with the DON on 6/15/11 at 1:45 P.M., he indicated the carpet obstacle and the wet floor were not recognized in general hazard prevention until after the incidents occurred. 3. The facility system of vacuuming floors was observed on 6/16/11 and 6/17/11 between 7:55 A.M. and 8:20 A.M., when Housekeeper #1 was utilizing the internal wall suction ports in one of two halls with a 50 foot hose attached to the vacuum head to sweep hall carpeting. Throughout the process, she vacuumed the carpet with the hose trailing behind an expanse the length of 3-4 resident doorways, crossing each threshold. She was unable to view potential resident traffic in the area behind her. In interview, during the observation, Housekeeper #1 indicated she was aware the hose has to be watched since it's a tripping hazard. On 6/20/11 at 12:10 P.M., the Housekeeping Supervisor indicated the vacuuming system was installed in both resident halls and staff were instructed to keep good hose control. She indicated the vacuuming was to be done primarily "...when residents are eating and out of the halls but it doesn't always work that way and really it's done anytime of day."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/20/11 at 2:00 P.M. the Housekeeping Supervisor indicated the facility did not have a policy and procedure for carpet sweeping. 3.1-45(a)(1) 3.1-45(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure staff prepared sanitation solution per facility policy, failed to ensure staff were knowledgeable regarding the testing of the sanitation	F0371	F371 F371 It is and shall continue to be the facility's policy to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute and serve food under sanitary conditions. The corrective action taken for the resident found to have been affected by the deficient practice is that no specific residents were identified. The corrective action taken to identify other residents having the potential to be affected is that all residents have the	07/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	solution, failed to ensure paper towels were available and easily accessible for drying of hands after washing and failed to ensure the trash receptacle had the appropriate lid to prevent contamination of hands when discarding paper towels during 3 of 4 observation days with the potential to affect 31 of 31 residents who received meals from the facility kitchen. Findings include: On 6/15/11 at 10:00 A.M., an observation in the kitchen indicated the paper towel dispenser was empty		potential to be affected by the same deficient practice. The corrective action taken for those residents is that a trash receptacle with a foot pedal for opening has been placed in the kitchen for disposal of paper towels used to dry hands. The paper towel dispenser is checked daily by housekeeping to ensure dispenser is full.. The Procedure to setting up the sanitizer buckets has been posted in the kitchen and the correct testing strips have been identified and placed in the kitchen. The measures or systemic changes put into place to ensure that the deficient practice does not recur is that an inservice has been conducted for kitchen and housekeeping staff specific to the issues identified. In addition all dietary staff have successfully completed a return demonstration on how to test the sanitizing solution in accordance with facility policy and procedure. The corrective action taken to ensure the deficient practice does not recur is the implementation of a Quality Performance Tool. This tool will be completed by Dietary and Housekeeping staff daily times three weeks, monthly times three months and quarterly times three quarters. The results will be reviewed in monthly QA to determine is further action is warranted. Completion Date 7-9-11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at the hand washing sink. Towels were obtained out of the cabinet above the sink after hand washing was completed by Cook # 1. The lid on the trash container to discard the paper towels after use had to be lifted and replaced by hand after discarding the paper towel. On 6/20/11 at 10:00 A.M., the paper towel dispenser above the handwashing sink was empty. Cook # 1 indicated that housekeeping would be bringing some in if there were no towels in the cabinet above the sink. There were no towels in the above cabinet, only the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	outer paper wrapper that contained them. The lid on the trash can had to be handled by hand to discard the paper towel (or any other item being discarded). On 6/15/11 at 10:05 A.M., Cook # 1 was asked to test the sanitation solution. Cook # 1 indicated there was not a solution bucket prepared that morning and proceeded to set one up to test using bleach and water. The test was completed with Quaternary Ammonium Compound (QAC) strips whereas the color indicator did not match the original container. The test strips			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	original color was yellow and turned white in color after being dipped. The indicator line on the container was in shades of green. Cook # 1 indicated, "100 ppm" while holding it next to the first green shade on the results line of the bottle and nodding his head as the strip matched the first block. On 6/16/11 at 9:30 A.M., Dietary Aid # 1 was asked to test the sanitation solution. The strip was dipped into the solution water and the strip turned a purple color. Cook # 1 indicated the Dietary Aid # 1 used the wrong testing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	strip and removed a container of testing strips (QAC) from his pocket and gave to her to use to test the solution. Again the test strip was white in color and did not match the shades of green on the indicator line of the original container to show the amount of sanitation solution present in the water. On 6/17/11 at 9:00 A.M., Cook # 1 tested the sanitation solution using the (QAC) yellow strips. He dipped the strip into the solution and the strip turned pale white in color not matching the indicator line of greens.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/20/11 at 10:00 A.M., an interview with Cook # 1 indicated use of the wrong strips to test the sanitation solution had been used and was preparing an inservice for the staff. On 6/20/11 at 10:15 A.M., Cook # 1 provided the procedures to setting up the sanitizer buckets. Procedures are as follows: 1. Use only 2 buckets, fill buckets with hot water to fill water line # 5 and water should be at least 75 degrees. 2. Place 1/2 teaspoon of bleach in each bucket and wait till it dissolves. Take a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PH strip and hold for 10 seconds and check against the scale. It should always be at 50-100 ppm (parts per million). 3. Sanitizing solution buckets should be make at 6 A.M., after breakfast, lunch and supper. If at anytime buckets become soiled, they are to be changed, in addition to the specific times. Bucket on cart is for non-food sanitizer. Bucket on counter is for food sanitizer. On 6/20/11 at 10:20 A.M., observation of the Precision Chlorine Test Paper bottle instructions indicated: Use			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155714	A. BUILDING 00 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK VILLAGE INC	200 W FOURTH ST OAKTOWN, IN47561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dry fingers to remove strip of paper from vial, dip strip into solution to be tested, without agitation and compare and compare immediately with color chart on label. This color indicates approximate strength of the solution in parts per million (ppm) available chlorine. 3.1-21(i)(2)			